Letter to the Editor

("IS ENDOSCOPIC EAR SURGERY AN ALTERNATIVE TO THE MODIFIED BONDY TECHNIQUE FOR LIMITED EPITYMPANIC CHOLESTEATOMA?" by Prasad et al.)

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"IS ENDOSCOPIC EAR SURGERY AN ALTERNATIVE TO THE MODIFIED BONDY TECHNIQUE FOR LIMITED EPITYMPANIC CHOLESTEATOMA?" by Prasad et al.

Dear Editor,

We carefully read the interesting article by Prasad et al., recently published on your journal [1]. In their paper the authors address the issue of epitympanic cholesteatoma surgery by presenting their retrospective case series of 269 ears treated by the modified Bondy technique and by discussing the role of the endoscopy in treating this kind of pathology. Although the paper represents an important contribution to this specific subject, several considerations must be made.

Starting from the material and methods subheading of the paper, it is honestly mentioned that few patients (not specifying how many) were contacted telephonically to gather the latest records: this method of assessing results is quite inaccurate, and those patients should have been excluded from

the analyses or at least censored. In fact it is obviously very difficult to assess a recurrence or a residual only by asking to the patients. Moreover out of 362 patients, 59 were lost at follow-up (16%). In the present case series the patients, which did not have an adequate follow-up (because made by phone, or because of the drop-out) is quite high and could represent a bias. In this perspective, the presented results could have underestimated recurrences, residuals, discharging ear and all other end-points analyzed.

About the comparison of the results of the paper to those of the endoscopic literature, there would be several points to argue. First of all, the case series presented by Prasad et al. [1] deals with "limited" attic cholesteatoma with preoperative intact ossicles, in 76.2% of cases laying laterally to the ossicular chain and in 24.1% with a limited extension medial to the incus. These results are compared to very different endoscopic case series from literature, in which not only "limited" attic cholesteatomas are included, but also extended attic pathologies involving anterior epitympanum, posterior epitympanum, laying medial to the ossicles, or with preoperative erosion of the ossicular chain. In conclusion, the results cannot be compared, due to completely different anatomical extension and pathologic stages. Second, the comparison of the results was made using an incomplete literature review, because other papers than those mentioned by Prasad et al. dealing with endoscopic technique results are present in literature [2].

Always commenting the results of Prasad et al. it is very surprising that only 1.5% of their case series had a post-operative discharging ear. It is a fact in our daily clinical practice, that patients with open cavities (regardless the surgeon or the hospital where they were operated) present in a relevant percentage of cases the necessity of periodic toileting, and quite often with a "wet" ear.

Moreover, since it is said that most of their patients have been able to perform underwater activities, it would be also interesting to know how and in how many patients Prasad et al. assessed the underwater limitations of the patients in their case series.

In the discussion subheading, Prasad et al. assert that cosmetically endoscopic ear surgery scores over open cavities in avoiding post-auricular scar. But actually, the most relevant cosmetic advantage of endoscopic techniques is to avoid very unpleasant meatoplasties, which as admitted by Prasad et al. must be very wide to avoid post-operative problems to the patients with open cavities.

We would also like to comment the figure 3 included in the paper: is seems to assert that by tilting the operating table or by adequate canaloplasties, limitations of the view of microscopic surgery can be overcome. The problem of the microscopic view it is not only that it has a forced straight view, unable to see around the corner, but also that at high magnification, it loses depth of field, so nullifying tridimensionality: those are only two of the main reasons why endosocopy can guarantee better view into the tympanic cavity.

We would like to conclude our letter saying that endoscopic ear surgery is spreading at a very fast rate all over the world and along the international otologic community, since its advantages of absence of external incisions, tissue preservation, optimal surgical filed view and around the corner exploration are now self-evident. Endoscopic surgery is also dramatically changing physiologic and surgical concepts in the middle and internal ear. Actually by mastoid preservation it is possible to maintain its buffer effect and ventilation gas exchanges. By precise visualization and restoration of the ventilation pathways it is possible to leave an almost intact ear after surgery, with better cosmetic results and very fast post-operative recovery. On the opposite the use of a canal wall down technique dating 1910 for treating *limited* attic cholesteatomas seems to us quite obsolete, and in particular in the era in which minimal invasively, natural orifice transluminal endoscopic surgeries, esthetic issues and QoL results are key-points of our routine clinical practice. So we would like to encourage every quaternary referral center dealing with otologic surgery to follow the natural progress of the techniques and to introduce endoscopy in their clinical practice, in order to avoid getting stuck in the past.

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